A G E N D A

Health & Care Partnership

Date:	**Monday, 25th October, 2004**
Time:	**10.30 a.m.**
Place:	**Council Chamber, Brockington, 35 Hafod Road, Hereford**
Notes:	Please note the **time, date** and **venue** of the meeting.

For any further information please contact:

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County of Herefordshire District Council

HEREFORDSHIRE COUNCIL

AGENDA

for the Meeting of the Health & Care Partnership

To: Councillor Mrs. L.O. Barnett (Chairman)
Councillor Mr. T. Willmott (Vice-Chairman)

Councillors Ms. S. Fiennes (Director of Social Care and Strategic Housing), Mrs. M.D. Lloyd-Hayes, Mr. E. Oram (Director of Education), R.J. Phillips, D.W. Rule MBE and R.V. Stockton

Others Mr. P. Bates (Herefordshire Primary Care Trust), Dr. M. Deakin (Herefordshire Primary Care Trust), Mr. R. Hamilton (Hereford and Worcester Ambulance Service), Ms. H. Horton (Voluntary Sector), Mrs. C. Moore (Herefordshire Primary Care Trust), Mrs. J. Newton (Hereford and Worcester Ambulance Service), Mr. D. Rose (Hereford Hospitals Trust) and Dr. I. Tait (Herefordshire Primary Care Trust)

Pages

1. APOLOGIES FOR ABSENCE

To receive apologies for absence.

2. NAMED SUBSTITUTES (IF ANY)

To receive details of any Member nominated to attend the meeting in place of a Member of the Partnership.

3. DECLARATIONS OF INTEREST

To receive any declarations of interest by Members in respect of items on this agenda.

4. MINUTES 5 - 12

To approve and sign the minutes of the meeting held on 5th July, 2004.

5. CONSTITUTION

(i) To approve the following change to the Constitution:

Under Paragraph 4.4: the words “(f) one shall be the Chairman of the Herefordshire Community Health Council” be replaced with “(f) one shall be the Chair of Primary Care Trust Patient and Public Involvement Forum; and (g) one shall be the Chair of Hereford Hospitals Trust Patient and Public Involvement Forum. “

The above change in membership reflects the fact that the Herefordshire Community Health Council has been abolished and replaced by two Public/Patient Involvement Forums. Ms A. Stokes (Chair of PCT PPI Forum) and Ms J. Boys (Chair of HHT PPI Forum) will be welcomed onto the Partnership as a result.

(ii) To note that further changes to the Constitution will be necessary in due course to reflect other membership issues, and changes to the structure and *modus operandi* of the constituent Health organisations.

6. JOINT HEALTH AND CARE COMMISSIONING GROUP - BRIEFING NOTES

To note the attached report of the Assistant Director of IMPACT in respect of items dealt with by the Joint Health & Care Commissioning Group on 13th September 2004. ***(Introduction by Jean Howard)***.

Report to follow.

7. THEME: SUBSTANCE MISUSE SERVICES IN HEREFORDSHIRE 13 - 30

- **Substance Misuse: A Community Policing Perspective**. To receive a presentation from Chief Inspector Ivan Powell, Police representative on the Herefordshire Community Safety and Drug Partnership.

- **Drugs and the National Curriculum**. To receive the attached report by Liam Kernan, Drug Education Development Officer, LEA.

- **Drug Abuse: The Health Issues**. To receive a presentation from Mark Hemming, PCT Locality Manager.

- **Herefordshire Alcohol Strategy: Progress and Challenges**. To receive the attached report and extract from the Hereford Alcohol Strategy 2003-6, and a presentation from Brendan Sheehy, Community Alcohol Services Coordinator.

8. KEY ISSUES AND PRIORITIES / FUTURE AGENDA ITEMS FOR THE HEALTH AND CARE PARTNERSHIP 31 - 38

To consider the attached report on the priority areas for joint working, led by the Health and Care Partnership Board and supported by the IMPACT team in 2004/5, and to agree a programme of work.

9. ANY OTHER BUSINESS

To consider any items of urgent business.

10. DATE OF NEXT MEETING

To note that the next meeting of the Health and Care Partnership is scheduled to take place at **10:30 a.m.** on **Thursday 13th January, 2004**, at **Brockington, 35 Hafod Road, Hereford**.

Future provisional meeting dates are as follows:

11th April, 2005
14th July, 2005
13th October, 2005
19th January 2006

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COUNTY OF HEREFORDSHIRE DISTRICT COUNCIL

BROCKINGTON, 35 HAFOD ROAD, HEREFORD.

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MINUTES of the meeting of the Health and Care Partnership held at Brockington, 35 Hafod Road, Hereford on 5th July, 2004 at 10.30 a.m.

Present:

Herefordshire Council:
Councillors: Mrs L O Barnett (Chair of Health and Care Partnership), Mrs M D Lloyd-Hayes, D W Rule, W J S Thomas.

Ms S Fiennes (Director of Social Care and Strategic Housing),
Ms A Heath (For Dr E Oram, Director of Education)

Herefordshire Primary Care Trust:
Mr P Bates (Chief Executive), Dr I. Tait (Chair of Professional Executive Committee), Mr T Willmott (Chair of PCT and Vice-Chair of Health and Care Partnership),

Hereford Hospitals Trust:
Mrs C Moore (Chair), Mr D Rose (Chief Executive)

Hereford & Worcester Ambulance Service:
Mr R. Hamilton, Mrs J Newton (Chair)

Other Member Representatives:
Mr W. Lyons (Chamber of Commerce)

In attendance: Ms J. Bruce, Mrs Y. Clowsley, Councillor P E Harling

Note: The outgoing Chair, Mr T. Willmott, took the meeting for the first item (ELECTION OF CHAIR). The newly elected Chair, Councillor Mrs L.O. Barnett, then took the remainder of the meeting.

1. ELECTION OF CHAIR

RESOLVED: That Councillor Mrs L.O. Barnett be elected Chair for the ensuing year.

2. APPOINTMENT OF VICE-CHAIR

RESOLVED: That Mr T. Willmott be appointed Vice-Chair for the ensuing year.

3. APOLOGIES FOR ABSENCE

Apologies were received from Dr M. Deakin, Mrs J. Frances, Mr S. Hairsnape, Ms J. Jones, and Councillor R. Phillips.

4. NAMED SUBSTITUTES

Ms A. Heath for Dr E. Oram.

5. DECLARATIONS OF INTEREST

There were no declarations of interest.

6. MINUTES

With reference to the minutes of the meeting held on 1st April, 2004, the following progress reports were noted:

- **Health and Care Partnership Away Day:** Subsequent to the resolution taken on 2nd February, 2004, the difficulties of holding an Away Day involving key Health Professionals had become apparent. It had therefore been decided to have the discussion on the key issues affecting the partnership organisations as an agenda item later in the next scheduled meeting.

- **Developing a Stroke Service in Herefordshire:** Mr P. Bates reported that the proposed options for provision of a stroke service were being finalised. One of the next key issues would be to identify funding.

- **Annual report of the Health and Care Partnership:** Mrs Y. Clowsley circulated copies of the finalised report at the meeting. Mr P. Bates said that he would welcome comments on the document at a future meeting.

RESOLVED: that the minutes of the meetings held on 2nd February and 1st April, 2004 be approved as a correct record and signed by the Chair.

7. JOINT HEALTH AND CARE COMMISSIONING GROUP BRIEFING NOTES

The Partnership received a report on issues dealt with by the Joint Health & Care Commissioning Group, and the report indicated where further information could be obtained.

During the ensuing discussion, the following key points were raised:

- **Joint Health & Care Commissioning Group:** The Partnership was informed of changes to the Joint Health & Care Commissioning Group (formerly the Health and Care Executive), including style and membership. It was noted that further changes were likely later in the year with the launch of the Children's National Service Framework and The Children's Bill. At that point, it would be possible to finalise commissioning arrangements.

- **Review of the Planning and Partnership Team:** Mrs Y. Clowsley reported that she had undertaken a review of the Planning and Partnership Team, and the implementation of the revised structure would begin immediately. The review had become necessary to ensure continuing good management of change principles and a clear multi agency approach to service planning and development in the future. The Team had been renamed IMPACT (Integrated Modernisation, Planning and Change Team). Mrs Clowsley was congratulated on securing the permanent post of Head of IMPACT.

- **Teenage Pregnancy Annual Report:** Councillor Mrs M.D. Lloyd-Hayes felt that the report was excellent, although it would have been beneficial to include contact details in respect of the various issues it had addressed. She said that it was imperative to involve schools more fully in sex education and strategies aimed at preventing unplanned teenage pregnancies. She reported that Dr C. Chima-Okereke, Director of Sexual Health Services, had offered to be directly involved with sex education in schools. In addition, Councillor Mrs Lloyd-Hayes suggested using the Courtyard Theatre as a

contact point from which to promote the teenage pregnancy strategy, because this venue was frequented by young people and was open during the evening, when other services, such as Connexions, were unavailable.

Mr P. Bates emphasised that the intention with such reports was to provide sufficient information without overwhelming the reader. He added that further information could be obtained from the authors of the reports when required. He intended to provide executive summaries for wider distribution, thereby limiting the circulation of the full report and saving resources. Members felt that this was an appropriate method of providing information, and agreed that any issues emerging from the reports which were felt to be more significant, would be put on future Partnership agenda.

- **Local Public Service Agreement 2:** This had been prepared by the Herefordshire Partnership and would be taken forward by Mrs J. Howard, Assistant Director, IMPACT. The Chair emphasised the need to focus on key issues in Local PSAs, due to the pressure on resources. Ms S. Fiennes said that she and Mr P. Bates would monitor progress and keep the Partnership informed.

RESOLVED: That the report be noted.

8. REPORTS ON THE CURRENT SECTION 31 ARRANGEMENTS

The Partnership considered a report in respect of the current Section 31 Agreements in place in Herefordshire. The report outlined the broad themes of each Agreement, and highlighted any common themes and any potential risks. An appendix to the report, listing the Section 31 Parternship Board Members, was circulated at the meeting. In addition to the report, the following points were made:

- **Section 31 Partnership Board Membership:** Councillor D. Rule questioned why only one elected member appeared on the Membership lists, and why input from Education had not been envisaged. Ms S. Fiennes explained that the membership had been chosen to reflect the services which formed part of the Agreements, and as such, had been specific to PCT and Social Care representatives. Mr P. Bates added that reports on the Agreements would be considered at regular intervals by Health and Care Partnership

- **Joint Community Equipment Store:** This facility had been the subject of an information report at a previous Partnership meeting and was continuing to develop. The Section 31 Agreement had been signed in response to a need to improve the performance of the service and the associated performance indicators.

- **Hillside Intermediate Care Resource:** Hillside had proved to be a highly successful and modern way of delivering health care. The Partnership felt that its unique ethos would have applications not only in health care, but in commercial and industrial settings also. It was hoped that Hillside would also be developed as an alternative to the hospital's Accident and Emergency Department in helping to prevent unnecessary hospital admissions, as a means of helping to reduce unnecessary referrals.

- **Integrated Mental Health and Learning Disability Services:** Mr P. Bates emphasised that insufficient funding had hampered some of the work required in these fields. Both services required a thorough review, particularly issues surrounding single assessment, information gathering and ICT. He explained the difficulties involved in creating a joint ICT system, and reported that the initial one-year timescale had proven to be unrealistic. He had sought advice on these issues from the Commission for Health and Audit. Members noted that, from a managerial perspective, the integration of the service at frontline level had brought marked improvements.

Overall, members felt that the Section 31 Agreements had worked exceptionally well, and noted that they had received no challenges from Audit. They acknowledged, however, that there remained several key issues which would need to be addressed in the near future.

Further progress with the Agreements would be reported at a future meeting.

RESOLVED: That the report be noted.

9. KEY ISSUES FACING PARTNERSHIP ORGANISATIONS

The Partnership received presentations from the following organisations on the principal issues which would need to be addressed in the forthcoming year and beyond:

Primary Care Trust

Mr P. Bates set out the current NHS Improvement Plan principles and said that the challenges facing the NHS were set in this context. The Plan stipulated that, by the year 2007/08, the NHS will offer:

- A maximum wait of 18 weeks for admission for treatment following referral by a GP;
- A choice of providers;
- Treatment by any facility that meets NHS standards and price;
- A wider range of service in Primary Care;
- Electronic prescribing;
- The expansion of Direct Payments for social care;
- Regulation and inspection by CHAI;
- Community matrons;
- Major investments to tackle chronic diseases;
- Progress to achieving a 40% reduction in death rates from heart disease and stroke;
- A health service making inroads into levels of smoking, obesity, etc;
- Local communities having greater influence over local services;
- All NHS Trusts to apply for Foundation Trust status;
- An expansion in staff number.

Standards for better health were diverse, and covered: safety, clinical and cost effectiveness, governance, patient focus, accessible and responsive care, public health, and care environment and amenities. The standards given were meant to be a minimum, and it was envisaged that the actual targets set would exceed those standards wherever possible.

For Herefordshire, the Primary Care Trust would aim to achieve the following:

- An increase in capacity and efficiency;
- Achievement of all access times;
- Prepare for the new marketplace of choice, and subsequent funding flows.
- Prepare for payment by results and Foundation Trusts;
- Maintain financial balance;
- Ensure wise investment in ICT;
- Focus on Public Health;
- Plan for the future, for example, developing a strategy for acute services;
- Investment in emergency medicine;
- Develop robust processes of chronic disease management;
- Design and implementation of new Out of hours service;
- Improvement in Stroke Services;
- Greater emphasis on Children's Services.

It was envisaged that the above would be achieved through partnership working, investment in staff pay, managing expectations and difficulties, and by being imaginative. New contracts and initiatives, such as Agenda for Change, would ensure that the Health pay bill would increase by 7.5 % in a couple of years, although it was noted that much of this funding had already been earmarked.

Social Care and Strategic Housing

Ms S. Fiennes outlined the priorities for Social Care and Strategic Housing as follows:

- Improving older people's services: Performance on assessment and care management; equipment/adaptations;
- Developing older people's services: Home Care changes; STARRS; Consolidating the SHAW transfer and development programme; Extra care housing in Hereford;
- Impact through partnership: Making capacity work to best effect, Every Child Matters/Herefordshire Child Concern Model; Decent housing and homelessness developments; Improving processes for vulnerable people (HHT and PCT, Ross Community Hospital, waiting and delays); Voluntary Sector (The Alliance and commissioning future services);
- Prospects/Capacity for improvement: Retention of excellent prospects for Children's services and ensuring promising prospects for adult services; Retaining housing performance at a high level.

Hereford Hospitals NHS Trust

Mr D. Rose reported that the Hospitals Trust would aim to achieve the following:

- Creating a vibrant hospital team: A staff survey had revealed that the Trust was felt to have overall good performance, with some weak areas. The results of the survey had been made available shortly after Mr Rose took up post, and had provided a useful snapshot. In order to regain some vibrancy in the hospital environment, it would be necessary to increase the presence/visibility of managers. Three clinical leaders, or chiefs of staff, would be appointed as a result. Recruitment and selection processes would be revised to ensure that the best staff were in post, and a new award system, called "One of the Hospital's Best" would be launched to improve staff motivation.
- Improving customer confidence: It would be necessary to give greater media publicity to achievements and improvements, to provide a smiling front-line team, and emit positive messages about what it was like to work in the hospital.
- Delivering a financial balance: The current £3.5 million gap between income and expenditure would have to be reduced.
- Achieving capacity in the right places: Work had already started on capacity management in the areas of emergency care and chronic disease management, and it was estimated that it would take under 2 years to address acute bed shortages.
- Supporting some key services: The Trust's work on a joint Paediatric plan with the PCT was cited as an example of the way in which key services could be supported. Areas such as Accident and Emergency would also be targeted.
- More stars and preparing for Foundation status: The Trust was working towards achieving a 3 star rating in the current year. Foundation status represented a fundamental policy change, and was undoubtedly the way to progress.
- Playing a part in the local community.

Hereford and Worcester Ambulance Service

Mr R. Hamilton reported that the Ambulance Trust was making significant changes to its service provision. He said that he had been appointed to post at a time when there were high levels of committed staff within the organisation, and that this would enable the Trust to progress positively:

- Patient Centred Care: The Trust would need to work towards improving its Key Access targets, and the public's understanding of them.
- Information Technology: The Trust had been heavily engaged in implementing cutting edge technology to improve its service. Currently, it was possible to send information about the condition of a patient directly from ambulance to hospital, and the aim would be to increase the use of this type of technology. The Service was aiming to be the first in the country to use similar diagnostic links between ambulance and GP, and to explore use of the same technology in relation to ultrasound and x-ray. Issues surrounding stroke care, and chronic disease management would also be researched.

- High Quality Clinical Care: Efficient use of data would help to develop services and create capacity. Improvements to quality would also be achieved by Implementing National Service Frameworks (Thrombolysis treatment, delivered as a NSF, had already been hugely successful), focussed training in key areas, empowering clinical and managerial staff to use their skills, attaining CNST/RPST accreditation, and developing a CHAI action plan.

- Improved health and reduction in inequality: The ambulance service would take a more active role in promoting public health, for example, smoking cessation, 'flu vaccination. It was intended to improve the health of the workforce along similar lines, so that they would be able to promote the issues from a point of understanding their merits firsthand.

  Improving equality for Herefordshire and Worcestershire would mean providing a better service to rural locations, so that they were reached within the 8-minute target. This might be achieved through employing "Basic Doctors" in rural areas, who would be able to attend the patient ahead of the ambulance. Mr Hamilton reported that the Trust's funding bid through the New Opportunities Fund/British Heart Foundation had been approved today, which meant that staff could now be trained as "first responders".

- First Class Workforce: An operational Services Review was currently examining the staff skill mix, resources, vehicles, and the type of people employed, as a way to improve the overall effectiveness of the workforce;

- Involvement of Patients and Public;

- Increased value for money: The Trust would change its ethos so that some patients would be treated at home and, when appropriate, not taken to hospital.

Mr W. Lyons reported on the significant demographic change that had occurred in Herefordshire, resulting in the county having a 20% higher number of residents aged 65 and over, than any other area in the West Midlands. The Partnership agreed that these figures would have an impact on the delivery of health services in Herefordshire. Mr P. Bates confirmed that the Health Service could make better use of these figures to date. Funding per capita was weighted in accordance with the population base, but it had not effectively kept pace with the increase in the number of elderly residents.

The Partnership identified the need to improve information sharing between the Council and the Health Service. Mr Hamilton commented that the Ambulance Trust held a wealth of useful information, but due to its small size, it lacked the people with the best skills to use and interpret it. Members agreed that this was a common problem, which needed to be solved. It would become necessary to share ICT systems, so that investment in equipment produced the maximum benefits to all partners.

Dr I. Tait expressed concern about the growing trend towards obesity in the younger generation, who might have greater need of health services in years to come, due to changes in lifestyle. This generation also had higher expectations of the health service. Members agreed that more work needed to be done to encourage people to improve their own health and fitness, and to understand the crucial role that they played.

It was agreed that greater use should be made of the voluntary sector, and one obvious service area was patient transport.

RESOLVED: That the reports, and subsequent discussion be noted, and arising therefrom, an action plan be devised for the Partnership.

10. PRIORITIES/FUTURE AGENDA ITEMS FOR THE HEALTH AND CARE PARTNERSHIP (BASED ON THE PRESENTATIONS GIVEN EARLIER IN THE MEETING)

Arising from the above discussion, the following actions were agreed:

- Mrs Y. Clowsley would put a draft agenda of priorities to IMPACT, and the Joint Health and Care Commissioning Group for discussion. The Group would then devise a list of actions for the Health and Care Partnership to undertake, based on what could be achieved with the existing resources. Particular attention would be paid to priorities over the next 12 months. As a starting point, some common themes had been identified which the Partnership might work on, and these included:
    - Decreasing the number of people staying unnecessarily in hospital, and being referred unnecessarily or inappropriately to hospital;
    - Older people, and managing their health care;
    - Children's Services (in particular, child protection);
    - Young people, and educating them to take greater responsibility for their own health care;
    - Co-ordinating and sharing public health information;
    - Steering/giving guidance to Section 31 Agreements;
    - Managing public expectations and improving public confidence;
    - Improving patient choice, and as professionals, gaining a greater understanding of what it was like to be a patient so that services would be tailored to the patients' experiences. It was noted that this approach might require a shift of team resources, and a different way of working, and this was to be explored;
    - Expanding on the role of the community/voluntary sector.
- The Partnership would receive a presentation on Economic Strategy.

11. ANY OTHER BUSINESS

There was no other business.

RESOLVED: That the report be noted.

12. DATE OF NEXT MEETING

It was noted that the next meeting of the Health and Care Partnership would be held at **10:30 a.m.** on **Monday 25th October, 2004** at **Brockington, 35 Hafod Road, Hereford**.

The meeting ended at 4.07 p.m. **CHAIRMAN**

DRUGS AND THE NATIONAL CURRICULUM

Report By: Liam Kernan, Drug Education Development Officer

Purpose

1. To update the Health & Care Partnership Board on the current situation with regard to Drug Education in Schools

Introduction

2. The whole approach to drugs education in schools has changed significantly over the past fifteen years. It has evolved from a 'Just Say No' message to being more mindful of what works and what the students want. The abstinence message, 'Just Say No' was not successful – seeming to encourage students towards more risky behaviour with drugs rather than steering them away from it. Students would either discount one substance, because they had been told to say no to it, but concentrate their efforts on another substance not covered in school - or they would try it anyway, find out that it did not kill them, tell all their friends, and this might then lead to teachers appearing to be discredited and all their substance use lessons then being ignored.

3. A different approach has been developed over recent years. Now there is a whole new ethos. To provide students with the information, understanding, skills and attitudes, in a credible way, to make informed decisions about their drug use, and other peoples. Whilst being very different from 'Just Say No', this still has the same values underpinning it. Nobody wants to see young people becoming damaged drug addicts of the future. This approach is all about talking about the good and the bad of drugs, preparing them for real-life situations they will find themselves in, allowing them to form their own attitude and informed opinion; all in a credible, teacher led way.

4. There is less emphasis on having a Police Officer, Customs Officer, Prison Guard or reformed addict in to talk about the harms of 'drug abuse'. The lessons are teacher led and focus on making decisions about personal risk, whether or not the student, as an individual, can see all the consequences of taking / not taking a particular substance. That is not to say the Police and other agencies don't play a part. Any teacher delivering a scheme of work can incorporate them in the lesson to bring their message to the students. Each agency is asked to deal with their own area of knowledge or expertise and not to stray outside of this.

5. When this document refers to 'drugs' or 'substances' it means - caffeine, ‘over the counter’ medicines, prescription medicines, alcohol, tobacco, solvents and illegal substances.

The National Curriculum

6. **Statutory & Non-Statutory**

The National Curriculum breaks school down into Key Stages. Key Stage 1 is years 1-2, 5-7 year olds. Key Stage 2 is years 3-6, ages 7-11. Key Stage 3 is years 7-9, ages 11-14. Key Stage 4 is years 10-11, ages 14-16.

Drugs education is not, in itself, a National Curriculum subject. Some of it is covered in Science, which is a National Curriculum subject, and is statutory. Below is a table of where drugs education comes into science - SC2 Life processes and living things;

Key Stage 1	Humans and other animals	2d; about the role of drugs as medicines
Key Stage 2	Humans and other animals	2 Health g; about the effects on the human body of tobacco, alcohol and other drugs, and how these relate to their personal health
Key Stage 3	Humans as organisms	2 Health m; that the abuse of alcohol, solvents, and other drugs affects health
Key Stage 4	Humans as organisms	2 Health m; the effects of solvents, alcohol, tobacco and other drugs on body functions

7. This is the science component, and covers the 'how and where' of drug education. It does not go into the why, possibly the most important part. Following the National Curriculum orders for science, a young person would know how the drugs work, what they do and all the damage that they cause. This essentially covers the health component. They might never get into the personal and social reasons behind substance use. Personal, Social and Health Education (PHSE) is where these areas would be found. PSHE is non-statutory, and is not a National Curriculum subject. As the PHSE curriculum is a programme of guidance only for schools they do not have to deliver it. Consequently, although schools endeavour to deliver these areas they are not always able to cover them as well as they would like.

8. Drug service workers write and promote packs of work, to achieve all the science orders, to be delivered in a PSHE setting. Drugs education and other subjects, such as sex education and relationships and anti-bullying, also fit into PSHE. There are elements of Citizenship (statutory at Key Stages 3 & 4), English (statutory) and many other National Curriculum subjects in all these packs - but they fit best within PSHE. This poses a problem for some schools, in establishing where best to fit this work. However, the packs always have other applications, so that schools can adapt how they are used to fit with other subject areas. The packs never go out to schools without training, to help the school see where they might fit them in and how they will approach

delivery of this sensitive issue, whilst remaining credible and approachable to the students.

Key Stage 1	**Just One Spoonful**	A big book approach to whole class teaching and learning, this pack concentrates on the issue – **all medicines are drugs, but not all drugs are medicines**. This pack deals with literacy and health education in one go. Seen as a nice way in, it is not very explicit due to the age of the students - talking mostly about medicines. This pack will be reviewed in the spring term.
Key Stage 2	**Taking Drugs Literally**	A big book/interactive whiteboard approach to whole class teaching and learning, **Taking Drugs Literally** satisfies the Literacy Strategy, whilst delivering key health education messages. The pack is versatile and enables teachers to go as deep as they feel comfortable - only brushing on the topics, yet satisfying the national curriculum or going more deeply into the issues surrounding substance use. Again age specific - this pack concentrates mostly on legal drugs, alcohol, and tobacco but does go into cannabis.
Key Stage 3	**Eastcorrie** **Neighbours**	A harm reduction, drama approach to teaching and learning, this pack is soap based and will be launched in November/December. Harm reduction has abstinence at its core, but is pragmatic about the whole drug / drug use situation. This pack concentrates on alcohol, but brings in smoking, teenage pregnancy, legal issues and touches on domestic violence and family issues.
Key Stage 4	**Balance**	A video based approach to teaching and learning, this is the **'Rachel's Story'** pack. Breaking the video down into 3 lessons, **Balance** looks at stereotyping, managing risk and support networks. It has been in schools for nearly two years and is continually well received.
Pupil Referral Units	**STONED**	**S**traight **T**alking **O**n **N**early **E**very **D**rug is a harm reduction / personal game approach to teaching and learning; focussing on those students most at risk from drugs, those in Pupil Referral Units. It is a one to one approach and encourages young people to take a good look at their own drug use through a third party.

9. Further to these packs of work, support is given to students, teachers and parents through the website - www.drugsfaqs.org - which is available to all on the Internet. It has two sections - facts and faqs (frequently asked questions). The facts are all you need to know about substances, what they do, what they look like, the legal situation, and there is a glossary of terms. The faqs section contains the ability to ask questions and read the answers to previously asked ones. It is all anonymous and well used. The site is maintained and updated regularly.

10. There is also some free training available to schools through MerciaNet South, a training organisation set up in conjunction with Herefordshire Community Safety & Drugs Partnership and Worcestershire Substance Misuse Action Team. This training is available to any professional in Herefordshire or Worcestershire that may come into contact with substances and their use. (Contact details at the end of this document).

Drugs: Guidance for Schools

11. DfES Guidelines for schools were published earlier this year about drug education and drug incidents procedures. Broken down into several chapters, this document supersedes al previous guidance, and has updated and amalgamated it all. The most frequently used chapters are –

The context for drug education – which sets the scene, discusses the aim of drug education, its evidence base, what pupils want, and a whole school approach to the key drugs;

- Alcohol
- Tobacco
- Cannabis
- Volatile Substances (aerosols, glue, lighter fuel)
- Class A drugs (heroin, cocaine, crack, ecstasy, etc.)

Planning and teaching of drug education – issues to consider when planning and teaching;

- Trends
- Existing knowledge
- Vulnerable pupils
- Curriculum organisation

It goes on to discuss – teaching and learning, real-life impact, peer education, external contributors, assessment, training, OFSTED and many others.

Good management of drugs within the school community – issues such as; Management responsibilities, confidentiality, role of the Police, drugs in schools, disposal and detection – including a section on sniffer dogs, encouraging schools ***not*** to use them.

Responding to drug incidents – this is the biggest section and the one schools need the most help with. This section includes discussion around; defining drug incidents, medical emergencies, a range or responses, parents / carers, staff conduct and drugs and recording an incident.

The school drug policy – sets the context, gives a purpose, policy development, involving the whole school, recording and disseminating, reviewing and updating, working with the media.

12. A conference was held on 20 May 2004 to disseminate these new guidelines to schools and about a third of our maintained schools attended. A few more have responded to a letter offering documents prepared on their behalf.

13. These guidelines are non-statutory and schools are not obliged to follow them. However, many schools have and it is encouraging working with so many, to make sure they get the drug message right and drug incidents are dealt with in a coherent and consistent way.

RECOMMENDATION

THAT Members note the contents of this paper and support the ongoing drug education work in schools.

BACKGROUND PAPERS

- Drugs: Guidance for Schools DfES March 2004
- MerciaNet South Training Courses Val Comley 01432 845739
- Any of the education documents are available on the number below.

HEREFORDSHIRE ALCOHOL STRATEGY: PROGRESS AND CHALLENGES

Report By: Brendan Sheehy, Community Alcohol Services Co-ordinator

Purpose

1. To inform the Health and Care Partnership of the progress and challenges in alcohol services against the Alcohol Strategy published in March 2004.

Background

2. Herefordshire has a population of approximately 174,000. Based on national statistics this indicates there are approximately 21,500 heavy / harmful drinkers in the County (0.27% of total population). This figure refers to males drinking between 21 – 50 units a week and women drinking between 14 – 35 units per week. Of that 21,500 approximately 5,200 will be very heavy or dependent drinkers. This means men who are drinking above 50 units a week and for women greater than 35 units a week.

3. It is difficult to provide a true and accurate figure for the cost of alcohol misuse to society, due to the wide implications and effects of its abuse. These include costs to the NHS, Social Care, the workplace, Police and Criminal Justice, Benefits Agency and others. Evidence would suggest that tackling alcohol misuse remains a low priority. Financial allocation for other substance misuse (illicit drugs, tobacco) far outweighs the money directed towards alcohol services. The National Alcohol Strategy (March 2004) was disappointing in that it gave no guidance or commitment to the future development of alcohol services. Public survey suggests alcohol misuse has a detrimental effect on society, and that not enough is being done to raise the awareness around the risks of alcohol and its misuse.

4. National Statistics state that approximately 1 in 25 adult males is physically dependent on alcohol. Nationally, 1 out of 6 attendees at Accident & Emergency has an alcohol related problem or injury. This figure rises at peak times to 8 out of 10. Someone with an alcohol problem occupies 1 in 4 male beds in general hospitals either as a primary or secondary cause of their admission. 1 person in 13 is dependent on alcohol in Britain (twice as many as are dependent on all forms of drugs, including prescribed).

Further information on the subject of this report is available from -
Brendan Sheehy, Community Alcohol Services Co-ordinator on 01432 383399
brendan.sheehy@herefordpct.nhs.uk

5. Alcohol is a factor in: 75% of domestic violence, 65% of murders, 50% of child protection cases, 47% of drowning and 20 to 30% of all accidents. Between 1st January and 31st August 2003, 216 people attended Hereford Accident and Emergency with alcohol related causes. This is a minimum figure as the data base coding is incomplete. This would equate to an annual figure of 324 (as a minimum, and with the Christmas period having not yet occurred). The 3 main reasons for attending were Accident, Deliberate Self Harm and Assault.

6. Hereford has higher than the national average for deaths by Suicide. Nationally, 15%- 25% of actual suicides are associated with alcohol. 65% of attempted suicides are linked with alcohol. As part of the local Mental Health Improvement plan Herefordshire has to provide evidence on how its services are planning to reduce this above average suicide number. Herefordshire Police are called to an average of 2,500 incidents a year where alcohol is a factor, leading to some 500 arrests.

Current Provision

7. Many workers in the Public sector have to deal directly or indirectly with the consequences of someone's drinking. In Herefordshire the Community Alcohol Service is the only organisation working solely and directly with people presenting with alcohol problems. Currently it has 3.5 full time staff employed by the Hereford Primary Care Trust and sits within the Mental Health Services Locality. These staff come from a variety of professional backgrounds with skills and training geared towards working with people with alcohol problems. The team is located in a small building in Gaol Street in Hereford City centre. The team provide assessment and interventions to the whole of the county and receive the majority of their referrals from GP's. The team provide a service to the other community mental health teams providing the opportunity to co-work with mental health service users who have a diagnosis of severe and enduring mental illness and a coexisting alcohol problems, (dual diagnosis). The Team along with Health Promotion provide Alcohol Awareness training to clinical and care staff in the NHS, Social Care and partner organisations.

8. In the period May to August 2003 CAS received 103 new referrals and offered 309 follow up appointments. At present the Team's caseload is 150. As well as providing counselling interventions, the team provide advice / information on alcohol (mis)use, with the purpose of education and harm reduction.

Further information on the subject of this report is available from -

Brendan Sheehy, Community Alcohol Services Co-ordinator on 01432 383399
brendan.sheehy@herefordpct.nhs.uk

Gaps In Current Alcohol Service Provision

9. Comprehensive alcohol service should reflect the wide spectrum of problems and difficulties that can present:

a) Health promotion / education. There is limited input into schools and industry and what is in place for under 18's tends to be driven by the drugs agenda. There are plans for CAS to offer Alcohol Awareness Days to local Industry this coming year targeting larger employers in the county. The aim of this training is to raise understanding of alcohol use / misuse and is targeted primarily at Human Resources, Managers, and Occupational Health staff. This is an area for investment and growth under the banners of Health Promotion, Harm Reduction and Early Intervention. Further exploration of alcohol awareness requirements in schools is needed.

b) Alcohol Counselling Service. The people of Herefordshire do not have any means of independently accessing information, advice or counselling about their alcohol use. This could be a significant intervention into the "softer end" of the alcohol problem. There are successful models of this throughout the country, where in larger cities, statutory and non-statutory services co-exist. A model for Herefordshire might be to train up existing counsellors to offer a brief intervention model, providing information, advice and counselling. It would be possible to set up such a service with a local provider.

c) Arrest and A&E Referral Workers. This role has been identified as needed for people between the ages of 17 – 40 who come into contact with Police or A & E as a result of their alcohol use. This is an area of unmet need presently, and the role could provide early intervention to reduce heavy and dependant drinking patterns as well as reduction in repeat offending, diversion from the criminal justice system and reduction in repeat A&E presentations. These workers would need to be of a sufficient clinical grade to offer assessment, to provide brief interventions on alcohol use and maintain a caseload. One important aspect of the work would be liaison, advice and support for Police and A & E services with referral on to other areas as necessary. Front line workers often feel frustrated confused, unskilled and unsupported with difficult and demanding clients. The role could also support developments within mental health with the development of a crisis resolution service, which aims to achieve quick access to services and appropriate treatment (in the least restrictive environment). There is local evidence to support this type of post, with the successful appointment of a Drug Arrest Referral worker based within the FAC Team and a Deliberate Self Harm liaison service

based in A&E. For this service to be effective it would be important to have clearly defined boundaries and relationships with mental health services, criminal justice and Hereford Hospital.

d) Staffing of Community Alcohol Service (CAS). An increase in the staffing within CAS could be used to improve the links and services offered to general hospitals for assessments of inpatients with alcohol problems, advice on management and general education. Increased staffing would enable CAS to raise its profile and work with C.M.H.T's and the inpatient unit. Clients with a dual diagnosis can sometimes be passed between services. Developing dual diagnosis training or identifying dual diagnosis workers would improve the management of this difficult client group. Dual diagnosis is usually applied to clients with a psychosis and alcohol or drug problem. However many clients in mental health use alcohol to medicate their symptoms and many clients with primarily an alcohol problem complain of anxiety states and low-grade depression. This suggests that the term dual diagnosis could have a far wider remit.

Probation

10. Currently the CAS provides pre-sentence reports and follow up and treatment. This amounts to one day a week at present. Given the amount of alcohol related crime, this is a potential growth area. Probation have to be selective about who they can refer to CAS due to the limited capacity.

Addiction Beds

11. It is sometimes not safe for clients to withdraw from a physical dependency on alcohol in the community. A general psychiatric bed is not always the most appropriate venue. Alternative venues need to be found for safe and dignified inpatient alcohol treatment.

Rehabilitation

12. There are no rehabilitation units in the County and occasionally clients are sent out of county to have rehabilitation. This is an expensive process and requires intensive follow up to improve chances of success. There are plans and finances allocated to set up a **Dry House** in Herefordshire but there are problems in finding a suitable venue.

Further information on the subject of this report is available from -

Brendan Sheehy, Community Alcohol Services Co-ordinator on 01432 383399
brendan.sheehy@herefordpct.nhs.uk

Housing

13. There is a need to develop specific housing for clients with alcohol problems. This needs to be staffed housing for clients who are still drinking but thinking about change (**a Wet House**). From there, clients could then move on to a dry house when they have made that commitment to change, then moving on to longer term supported housing. If run by a non-statutory service then there might be potential income from clients through the supporting people initiative and their benefits. If this facility had an addiction bed it would have to register as a nursing home, which would incur extra costs.

Developing Social And Emotional Competencies

14. In alcohol work, stopping drinking is not enough; clients who decide to change their relationship with alcohol will need to replace it with other activities and behaviours. When drinking at harmful levels, there are other problems caused by their drinking and they are the reasons why people drink. Both these issues need to be addressed in order to prevent or reduce relapse. If clients have been drinking at significant levels for a long time, their abilities to manage the practical day-to-day issues of life and their emotions may be severely limited. Clients with these needs may need a significant degree of training and support to master or re-learn these techniques in order to integrate with society.

Support Workers

15. From January 2003, the Community Alcohol Service has had two support workers under the Supporting People initiative. Their brief is to help people maintain their tenancies and help them with problems with their accommodation, budgeting and to re-develop alternatives to drinking. This project is going well and the role has increased to 3 workers since January 2004.

Therapeutic Input

16. Some of the services clients may have had traumatic or abusive experiences in early life which have been the trigger for their drinking now. For clients who have embarked on a period of sobriety or reduced drinking It may be appropriate to provide counselling or psychotherapy to encourage longer-term change. The NHS availability of appropriate counselling is severely limited and private therapy can be expensive.

Further information on the subject of this report is available from -

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brendan.sheehy@herefordpct.nhs.uk

User Survey

17. In September 2003 CAS launched a Service User survey and subsequent focus group. The results of this identified that user's felt they would greatly benefit from being able to directly access the service.

The Cost Of Alcohol Misuse

18. The true cost of alcohol misuse to the nation is the subject of ongoing debate as it has far reaching implications in all areas of life, having direct effects on the user but also indirect effects on others such as spouses, children, employers etc.

Alcohol Concern considers the cost at present to be:	**£10.6 Billion**
With a cost to the NHS of:	**£3 Billion**
National population	65,000,000
Herefordshire population	174,000
Herefordshire population as % of national	0.27%
Alcohol misuse cost to Herefordshire	**£28,619,730**
Cost to Herefordshire NHS (Acute Trust, Primary Care Trust, Ambulance Trust)	**£8,100,000**

Bulmers indicate that they may own 3.17% of cost

Current CAS Budget	£165,360
Current Budget for Drug and Alcohol placements (rehab)	£169,160.

Income generated from tax Revenue of alcohol sales **£11.5 Billion**

RECOMMENDATION: That the report be noted.

Further information on the subject of this report is available from -

Brendan Sheehy, Community Alcohol Services Co-ordinator on 01432 383399
brendan.sheehy@herefordpct.nhs.uk

Extract from the Herefordshire Alcohol Strategy 2003-6

GAPS IN SERVICE

Allocation of community care funds to alcohol services

The pooled budget arrangement for Mental Health services, using the new Freedoms and Flexibility's legislation needs to consider the most appropriate way of ensuring that funding for people who seriously misuse alcohol is available.

Community Alcohol Service

Connections between Accident and Emergency, Police departments and the specialist alcohol services needs to be reviewed to ensure that services are available for these front line agencies to refer on to. This needs to be looked at in the context of current staffing levels consisting of 3.5 posts, which places inevitable restrictions on time available for this and other service provision.

Coordination

Work is going on in the major organisations around alcohol services and responses to alcohol abuse and related behaviours. It is however fragmented, poorly coordinated. For example the health and social dimension is dealt with locally through the Health and Care Partnership and the offending element by the Community Safety Partnership. A recent decision has been made to redress this by looking at the membership of the two relevant groups – the Alcohol Strategy group and the Alcohol Implementaion Group and creating a single group to take forward the combined agenda.

The National Alcohol Strategy should raise the profile of Alcohol Services Nationally and Locally

A range of day opportunities

There are limited opportunities for service users to access specialist day opportunities and establish informal and/or peer group support networks. More emphasis needs to be placed on the need for practical assistance to access "ordinary life" activities and opportunities.

Dual Diagnosis

A proportion of people with serious mental illness also have significant alcohol related problems. In addition, people identified as having alcohol related problems often have significant mental health needs. Since the work on this strategy started, a dual diagnosis task group has been established and will soon be in a position to make recommendations.

Health Promotion

There is a lack of effective promotion of the damaging effects of alcohol use, by the media, both locally and nationally. The 'cool' image of the product as portrayed though advertising far outweighs the promotion of 'sensible' drinking.

Hospital In-Patients
It is well established that a significant proportion of patients admitted to medical, surgical and other hospital departments have significant alcohol related problems. Although these problems are associated with a significant morbidity they are often not identified. This points to a need for improved training. Even when problems are identified there is no appropriate on site service response.

Housing
Continue to develop a range of housing and support to help people maintain their tenancies

Knowledge Base
There are concerns about a limited knowledge base, levels of experience and confidence of professional staff in statutory, voluntary and independent sector agencies. A programme for raising awareness of alcohol issues amongst Health professionals is underway (Health Promotion/CAS) in parallel with a programme for primary care practice staff.
There is a wider need for skills based training and ongoing supervision in all agencies, which will require appropriate planning and investment.

Older People
There is a lack of designated and appropriately trained personnel in the Community Alcohol Service to meet the needs of this age group, through training and education.

Protocols
Clear protocols for accessing services and for referring between services are required, as well as ensuring that a continuum of care is available to meet needs at different levels of intervention.

Relatives
There is insufficient help available to the carers and relatives of problem drinkers. Young carers in particular have long-term problems that should be addressed. A review of carers needs is currently being done and will start to address these needs.

Services geared to women's needs
Locally there are no designated alcohol services for women.
.
Social alternatives to alcohol based recreation
There is a paucity of affordable social and recreational options for young people that do not encourage the use of alcohol. There are some examples of successful events run by Crime Stoppers Council/Police/Health Promotions that have been well used by this age group, such as SNAP Dance Nights for young clubbers (4 times a year), backed up with related programmes for schools.

Voluntary Sector Involvement
There is no voluntary sector involvement in assessment and treatment within Herefordshire. This means that individuals have little choice about where to seek help. This may in turn inhibit some potential users from seeking the help they need. Voluntary organisations often provide easy access walk-in services and provide first level counselling in a non-stigmatising way. The result of which can lead to earlier and timely interventions being made.

Workplace alcohol policies
Work needs to be undertaken to ensure that major statutory and non-statutory employers have coherent and appropriate alcohol policies. It is important that these policies provide guidance to staff and offer help rather than being seen as punitive.

PRIORITIES

Establish a **Local Implementation Team** to develop Alcohol Services in Herefordshire and to implement the Local and National Strategies, comprising major statutory organisations, clinicians, users, carers and relevant voluntary sector representatives. It would coordinate alcohol developments and be the champion of alcohol related needs.

The group should produce a detailed action plan and establish **time limited** task groups to achieve specific pieces of work initially based on the identified priorities in this document.

This group should be responsible for contributing to the Three Year Delivery Plan and Modernisation Plan and ensure all resource implications are fed into the relevant financial frameworks.

An Alcohol Implementation Team, which reports to the Community Safety Partnership, already exists and it would be more efficient and cost effective to amalgamate both agendas. This would avoid duplication and the need for some individuals to attend two groups.

Review Community Alcohol Service in the light of the National and Local Strategies, leading to a development plan for the next three years. This should involve the re-provision and re-allocation of some resources, as well as a need for some additional resources. This review should particularly address the gaps identified in this strategy e.g. services for older people.

Within the context of the **model** develop clear and transparent referral protocols that facilitate appropriate access.

Ensure **funding** for alcohol services is addressed as part of the pooled budget arrangement for Mental Health.

Review **workplace alcohol policies** and develop proposals for a consistent approach across all agencies.

Review and make recommendations about a range of **day opportunities, employment opportunities, education and retraining opportunities and recreational activities.**

Consider the services that are needed but currently not provided and which could be developed by the **voluntary sector.** Then consider how this service design can best be met by relevant voluntary sector organisations.

Develop and evaluate **Health Promotion** schemes to encourage the safe and sensible use of alcohol.

Develop a comprehensive **education and training** programme for school and workplace settings.

Identify existing **counselling services,** establish what is required at each level of intervention and identify gaps.

Identify the unique **needs of women** who experience difficulties caused by alcohol and make recommendations.

Publish a **resource directory** both in hard copy and electronically to provide easily accessible information for the public and which could also be available to NHS Direct.

Develop a specification for a **young persons alcohol worker**

Encourage **local planners** to take every opportunity to develop non-alcohol related facilities in both the city and rural towns villages.

Develop proposals for a more effective **local media** approach to alcohol related issues. This is being undertaken by the Media - setting group as part of the Mental Health National Service Framework, Standard One.

Develop a **first point of contact service** to effectively refer people seeking help to the most appropriate services.

THE WAY FORWARD

Agree composition and terms of reference of the combined Alcohol Implementation team. **Action: Paul Dubberley / Mike Thomas**

Develop a detailed action plan based on priorities, with milestones and deadlines. **Action: Alcohol Implementation Team**

Establish task groups as needed. **Action: Alcohol Implementation Team.**

Identify resource implications and feed into financial planning cycles.
Action: Alcohol Implementation Team.

Agreed and signed off Health and Care Executive 10/3/03

For further information please contact:

Jean Howard,
Assistant Director Planning and Partnership,
Health Development Directorate,
Primary Care Trust,
Belmont Abbey,
Herefordshire.
HR2 9RP

KEY ISSUES AND PRIORITIES FOR PARTNERS IN JOINT WORKING IN HEREFORDSHIRE IN 2004/5

Report By: Yvonne Clowsley, Head Of Integrated, Modernisation, Planning And Change Team (Impact)

Purpose

1. This paper is to stimulate discussion and agreement on the priority areas for joint working led by the Health and Care Partnership Board and supported by the IMPACT team in 2004/5.

Single Agency Priorities For 2005/6

2. NHS Priorities for 2005/6

- A choice of providers;
- A maximum wait of 18 weeks for admission for treatment following referral by a GP;
- Treatment by any facility that meets NHS standards and price;
- A wider range of service in Primary Care;
- Electronic prescribing;
- The expansion of Direct Payments for social care;
- Regulation and inspection by CHAI;
- Community matrons;
- Major investments to tackle chronic diseases;
- Progress to achieving a 40% reduction in death rates from heart disease and stroke;
- A health service making inroads into levels of smoking, obesity, etc;
- Local communities having greater influence over local services;
- All NHS Trusts to apply for Foundation Trust status;
- An expansion in staff number.

The standards given nationally were meant to be a minimum, and it was envisaged that the actual targets set would exceed those standards wherever possible.

3. Local NHS Priorities for 2005/6

For Herefordshire, the Primary Care Trust would aim to achieve the following:

- An increase in capacity and efficiency;
- Achievement of all access times;
- Prepare for the new marketplace of choice, and subsequent funding flows.
- Prepare for payment by results and Foundation Trusts;
- Maintain financial balance;
- Ensure wise investment in ICT;
- Focus on Public Health;
- Plan for the future, for example, developing a strategy for acute services;
- Investment in emergency medicine;
- Develop robust processes of chronic disease management;
- Design and implementation of new Out of hours service;
- Improvement in Stroke Services;
- Greater emphasis on Children's Services.

4. Social Care and Strategic Housing Priorities for 2005/6

- Improving older people's services: Performance on assessment and care management; equipment/adaptations;
- Developing older people's services: Home Care changes; STARRS; Consolidating the SHAW transfer and development programme; Extra care housing in Hereford;
- Impact through partnership: Making capacity work to best effect, Every Child Matters/Herefordshire Child Concern Model; Decent housing and homelessness developments; Improving processes for vulnerable people (HHT and PCT, Ross Community Hospital, waiting and delays); Voluntary Sector (The Alliance and commissioning future services);
- Prospects/Capacity for improvement: Retention of excellent prospects for Children's services and ensuring promising prospects for adult services; Retaining housing performance at a high level.

5. Hereford Hospitals NHS Trust Priorities for 2005/6

- Creating a vibrant hospital team: A staff survey had revealed that the Trust was felt to have overall good performance, with some weak areas. The results of the survey had been made available shortly after Mr Rose took up post, and had provided a useful snapshot. In order to regain some vibrancy in the hospital environment, it would be necessary to increase the presence/visibility of managers. Three clinical leaders, or chiefs of staff, would be appointed as a result. Recruitment and selection processes would be revised to ensure that the best staff were in post, and a new award system, called "One of the Hospital's Best" would be launched to improve staff motivation.
- Improving customer confidence: It would be necessary to give greater media publicity to achievements and improvements, to provide a smiling front-line team, and emit positive messages about what it was like to work in the hospital.
- Delivering a financial balance: The current £3.5 million gap between income and expenditure would have to be reduced.
- Achieving capacity in the right places: Work had already started on capacity management in the areas of emergency care and chronic disease management, and it was estimated that it would take under 2 years to address acute bed shortages.
- Supporting some key services: The Trust's work on a joint Paediatric plan with the PCT was cited as an example of the way in which key services could be supported. Areas such as Accident and Emergency would also be targeted.
- More stars and preparing for Foundation status: The Trust was working towards achieving a 3 star rating in the current year. Foundation status represented a fundamental policy change, and was undoubtedly the way to progress.
- Playing a part in the local community.

6. Hereford and Worcester Ambulance Service Priorities for 2005/6

- Patient Centred Care: The Trust needs to work towards improving its Key Access targets, and the public's understanding of them.
- Information Technology: The Trust had been heavily engaged in implementing cutting edge technology to improve its service. Currently, it was possible to send information about the condition of a patient directly from ambulance to hospital, and the aim would be to increase the use of this type of technology. The Service was aiming to be the first in the country to use similar diagnostic links between ambulance and GP, and to explore use of the same technology in relation to ultrasound and x-ray.

Issues surrounding stroke care, and chronic disease management would also be researched.

- High Quality Clinical Care: Efficient use of data would help to develop services and create capacity. Improvements to quality would also be achieved by Implementing National Service Frameworks (Thrombolysis treatment, delivered as a NSF, had already been hugely successful), focussed training in key areas, empowering clinical and managerial staff to use their skills, attaining CNST/RPST accreditation, and developing a CHAI action plan.
- Improved health and reduction in inequality: The ambulance service would take a more active role in promoting public health, for example, smoking cessation, 'flu vaccination. It was intended to improve the health of the workforce along similar lines, so that they would be able to promote the issues from a point of understanding their merits firsthand.

  Improving equality for Herefordshire and Worcestershire would mean providing a better service to rural locations, so that they were reached within the 8-minute target. This might be achieved through employing "Basic Doctors" in rural areas, who would be able to attend the patient ahead of the ambulance. Mr Hamilton reported that the Trust's funding bid through the New Opportunities Fund/British Heart Foundation had been approved today, which meant that staff could now be trained as "first responders".
- First Class Workforce: An operational Services Review was currently examining the staff skill mix, resources, vehicles, and the type of people employed, as a way to improve the overall effectiveness of the workforce;
- Involvement of Patients and Public;
- Increased value for money: The Trust would change its ethos so that some patients would be treated at home and, when appropriate, not taken to hospital.

Joint Priorities For 2005/6

7. Common Themes Identified For The Partnership To Develop

- Decreasing the number of people staying unnecessarily in hospital, and being referred unnecessarily or inappropriately to hospital;
- Producing viable and appropriate alternatives to hospital care, where appropriate;
- Developing a strategy and service model of services for Older people, and managing their health care;

- Developing joint plans, commissioning arrangements and service plans for Children's Services (in particular, child protection);
- Developing the Child Concern Model;
- Developing common assessments, care plans and key workers for children with complex needs;
- Educating young people to take greater responsibility for their own health care;
- Co-ordinating and sharing Public Health information;
- Steering and giving guidance to Section 31 Agreements;
- Managing public expectations and improving public confidence;
- Improving patient choice, and as professionals, gaining a greater understanding of what it was like to be a patient so that services would be tailored to the patients' experiences. It was noted that this approach might require a shift of team resources, and a different way of working, and this was to be explored;
- Expanding on the role of the community and the voluntary and independent sectors.
- Ameliorating the impact of financial pressures across agencies, by joint working to maximise limited resources;
- Developing joint service planning that dovetails across agencies, using the IMPACT team to ensure cohesion;

8. Possible areas of influence

- **Marketing the services**

  Increase Public confidence

  Managing expectations

  Pro-active PR

  Providing clear and appropriate information to the Public

- **Maximising the role of the Council and NHS as model employers**

  Demonstrating by example, i.e. Flu vaccination uptake

  Health lifestyles encouraged for staff

  Encourage environmentally friendly transport options

- **Maximising use of data and information**

  Sharing demographic data

  Sharing Public Health data

  Encourage use of NHS numbers

Further information on the subject of this report is available from -

Yvonne Clowsley, Head of IMPACT, on 01432 344344

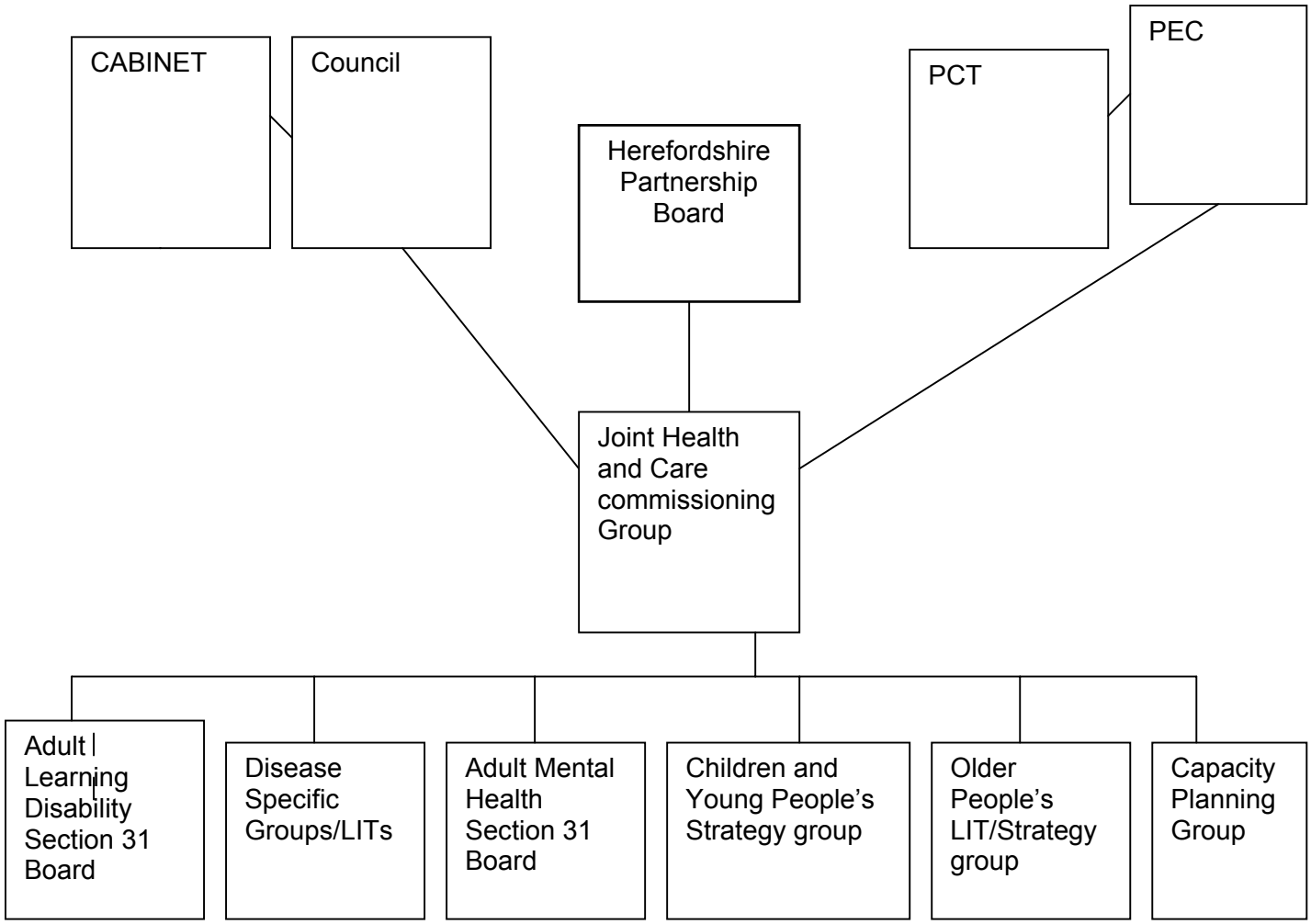
- **Including the Voluntary and Independent Sectors in early discussions on service planning**

Proposed Future Actions

9. Linking of existing groups to ensure joint service development planning in each of these areas:

Learning disability Section 31 Board	To develop further and
Mental Health Section 31 Board	could form groups for
Children's and Young People's Strategy Group	commissioning
Older People's LIT/Strategy Group	and integrated
Disease Specific Groups	service provision.
Capacity Planning Group	

10. The sort of structure that could support this function might be:



Further information on the subject of this report is available from -

Yvonne Clowsley, Head of IMPACT, on 01432 344344

RECOMMENDATION

THAT the Partnership agrees on its the priority areas for joint working, led by the Health and Care Partnership Board and supported by the IMPACT team in 2004/5, and a programme be developed therefrom.